# Lancaster Care Center

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## CONSENT FOR THERAPY AND PAY STATUS

☐ New Resident ☐ Change in Status

To: ______________________________ Resident Name: ____________________________
______________________________ Date Telephone Contact: ______________________
______________________________ Tele. Approval? ☐Yes ☐No Initials__________
Date Sent Notice: ___________________________

This facility is a Medicare Certified Skilled Nursing Facility which provides Physical, Occupational, and Speech Therapy services.

☐ PHYSICAL ☐ OCCUPATIONAL ☐ SPEECH (check) services have been ordered by Dr. ____________ for the following reasons:_______________________________________________
_____________________________________________________________________________.

A review of the resident's medical history and condition by the physician and therapist indicates that the services are medically reasonable and necessary. The item checked below is an explanation of the current payment source for the therapy services provided. Your signature is required for approval so that we may proceed with therapy as soon as possible.

☐ **MEDICARE B.** Up to $1880.00 of Physical/Speech Therapy and up to $1880.00 of Occupational Therapy services indicated above will be billed to the Federal Medicare Program. Under Medicare B guidelines it is necessary for the Resident, responsible party, or Medical Assistance program (if eligible) to pay the annual deductible of $140.00 (if not met) plus the 20% Medicare B does not cover, plus any amounts in excess of $1880.00

**NOTE:** If the above resident has supplemental insurance coverage that pays for some or all of the deductible and amounts not covered by Medicare B and the box is checked below indicating that the facility does not have record of that coverage, please provide the insurance company name and address and the policy number when you return this form.

☐ Medicare Advantage Plan. May cover Physical, Occupational and Speech Therapy. Therapy services will be billed to the Resident's Medicare Advantage Plan. Some Advantage plans may follow Medicare B guidelines regarding the $1880.00 therapy cap based on the information as stated above. Resident will be responsible for annual deductible (if applicable) and any amounts in excess of $1880.00 (if applicable.) Prior authorizations may be required.

☐ **PRIVATE PAY.** Based on our determination, effective ___/___/___ the prescribed services indicated above are not covered under Medicare B due to the following:

- ☐ Resident not enrolled in Medicare B program
- ☐ Resident does not meet Medicare B criteria.
- ☐ Resident has or will exceed limit for Physical/Speech Therapies.
- ☐ Resident has or will exceed limit for Occupational Therapy

Therefore, beginning ___/___/___ no payment under Medicare B can be made. Under law, a beneficiary or authorized representative, if dissatisfied with the Determination of ineligibility may request a review through local Social Security Administration office.
The Resident will continue to be seen for ___Evaluation Only ___Treatments per week. The amount of time in therapy may vary. All charges will be billed directly by the therapy company.

☐ **ANNUAL DEDUCTIBLE AND AMOUNTS NOT COVERED BY MEDICARE B /MEDICARE ADVANTAGE PLANS** will be billed to:

- ☐ Medical Assistance Program
- ☐ Your Supplemental Insurance Policy
- ☐ Resident Responsibility (**NOTE:** The Facility does not have any record of a Supplemental Insurance Policy.)
- ☐ Medicare Advantage Plan – Resident Responsibility (co-payments and deductibles may or may not apply. Please see your policy for coverage benefits.)

Please do not hesitate to contact the therapist or facility business office if you need further explanation before signing this document. Please return this signed document in the enclosed envelope. A copy will be sent back to you for your records.

Sincerely,

__________________________________

Therapist Signature and Phone Number

YOUR SIGNATURE INDICATES THAT (1) YOU AGREE WITH PROVISIONS OF THE PAYMENT SOURCE(S) DESCRIBED ABOVE AND (2) YOU AUTHORIZE MEDICAL INFORMATION TO BE RELEASED TO THE MEDICARE PROGRAM, SOCIAL SECURITY ADMINISTRATION AND INSURANCE COMPANY FOR PROFESSIONAL AND CLAIMS PURPOSES.

Dated:______________________

____________________________________________________________________

Signature of Resident/Responsible Party/Guardian/Health Care Power of Attorney/Financial Power of Attorney